PRINTED: 03/22/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495318	B. WING		R-C 09/13/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 621 BERRY HILL ROAD SOUTH BOSTON, VA 24592	1 03/13/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
{F 000}	INITIAL COMMENTS	6	{F 00	0}	
	standard survey cone 8/10/17, was conduct complaints were inve Corrections are requ	edicare/Medicaid revisit to the ducted 8/8/17 through ted on 9/13/17. No estigated during the survey. ired for compliance with 42 ederal Long Term Care			
{F 279} SS=D	92 at the time of the consisted of 11 curre (Residents # 101 three	ough 111). EHENSIVE CARE PLANS	{F 27	·9}	10/15/17
	assessments comple months in the resider results of the assess	ust maintain all resident eted within the previous 15 nt's active record and use the ments to develop, review ent's comprehensive care			
	483.21 (b) Comprehensive (Care Plans			
	comprehensive perse each resident, consist set forth at §483.10(dincludes measurable to meet a resident's and psychosocial ne	develop and implement a con-centered care plan for stent with the resident rights c)(2) and §483.10(c)(3), that objectives and timeframes medical, nursing, and mental eds that are identified in the ssment. The comprehensive ribe the following -			
ARODATORY	DIRECTOR'S OR PROVIDED	SUPPLIER REPRESENTATIVE'S SIGNATUR) DE	TITLE	(X6) DATE

Electronically Signed 09/22/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495318	B. WING		1	R-C / 13/2017	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 621 BERRY HILL ROAD SOUTH BOSTON, VA 24592		03/13/2017		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
{F 279}	or maintain the resid physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the runder §483.10, inclutreatment under §485. (iii) Any specialized serehabilitative service provide as a result of recommendations. If findings of the PASA rationale in the resident's representationale in the resident's representational endicates and the resident's profuture discharge. Fact whether the resident community was assellocal contact agencies entities, for this purpose. (C) Discharge plans plan, as appropriate, requirements set fort section. This REQUIREMENT by: Based on observation	are to be furnished to attain ent's highest practicable dipsychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not resident's exercise of rights ding the right to refuse 3.10(c)(6). Services or specialized so the nursing facility will final part of part of part of the services with the RR, it must indicate its ent's medical record. In the resident and the attive (s)- The part of the services and potential for collities must document to desire to return to the resident and any referrals to the services and/or other appropriate	{F 27	Resident #111 care plan was up on/or before September 30, 201			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
					F	R-C
		495318	B. WING		09	/13/2017
NAME OF P	ROVIDER OR SUPPLIER			${\tt STREETADDRESS,CITY,STATE,ZIPCODE}$		
DEDDY U	LL NUDEING HOME			621 BERRY HILL ROAD		
BERKY HI	LL NURSING HOME			SOUTH BOSTON, VA 24592		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 279}	Continued From page	e 2	{F 279	9}		
	comprehensive planeresidents in the survehad no plan of care of specialized "Rock and The findings include: Resident #111 was an 3/30/17 with diagnost schizophrenia, seizur accident (stroke), diapressure. The minim 7/7/17 assessed Resimpaired cognitive skextensive assistance On 9/13/17 at 8:45 an observed seated in a the hallway near the unit. The back of the With his hands on the #111 was leaning for attempting to propel fivere not supported a inches from the floor. wheelchair were in the foot rest strapped up resident made repeat in the chair without an Resident #111 was of 9:30 a.m. and at 10:00 wheelchair, leaning for unsupported. The resident made repeat in the chair yithout an Resident #111 was of 9:30 a.m. and at 10:00 wheelchair, leaning for unsupported. The resident made repeat in the chair yithout an Resident #111 was of 9:30 a.m. and at 10:00 wheelchair, leaning for unsupported. The resident #10 was a supported.	of care for one of 11 ey sample. Resident #111 eveloped regarding use of a d Go" wheelchair. dmitted to the facility on es that included res, cerebrovascular betes and high blood um data set (MDS) dated ident #111 with severely ills and to require the of two people for transfers. m. Resident #111 was specialized wheelchair in nursing station on his living wheelchair was reclined. e front wheels, Resident ward in the wheelchair forward. The resident's feet and were approximately 5 The foot rests on the e up position with the left with a rubber band. The ted efforts to propel forward my forward movement. beserved again on 9/13/17 at 10 a.m. seated in the reclined orward with his feet sident made repeated		reflect use of rock and go chair interventions related to position by Minimum Data Set (MDS) C Registered Nurse (RN). A 100% audit of all residents was conducted on/or before Sept. 3 Administrative Nursing Staff (D Nursing, Assistant Director of N Staff Facilitator, Quality Improventures and/or Minimum Data Seidentify all residents who utilize specialized chair. The careplant person identified was updated to the use of the specialized chair interventions to include position chair by the MDS nurse with overthe Director of Nursing before C 2017. The interdisciplinary care plant members (Dietary manager, MI Coordinator, Social Services Di Activities Director) have been resulted by the Administrator on the requision of the resident and ensure the specialized chairs are care plant interventions to include position chair by October 5, 2017. An audit will be completed of 10 plans to include care plans for 1 #111 weekly x 8 weeks then momonth by Director of Nursing, A Director of Nursing, Staff Devel	as 0, 2017 by irector of Jursing, ement et Nurse) to a s for each to reflect with hing of the rersight by October 15, team DS irector and e-educated uirements e care plan at hined with hing of the coresident on the president on	
	success. Resident #111's clinic resident fell from the	cal record documented the wheelchair while leaning nursing note dated 9/6/17		Coordinator and/or Quality Impl Nurse to ensure all specialized care planned with intervention the the positioning of the chair. The Administrator will review and in Care Plan Audit Tool weekly x 8	chairs are to include e itial the QI	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
					R	-c
		495318	B. WING _		09/	13/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIR	PCODE	
DEDDY				621 BERRY HILL ROAD		
BERRY HILL NURSING HOME				SOUTH BOSTON, VA 24592		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
{F 279}	station leaning forw to the floor hitting leapparent injuries" to the emergency rethe same day without occupational therapin response to the fwheelchair and postherapy note dated [patient] appropriate [wheelchair]. Recoreclined position who supervised" Resident #111's pladocumented no prointerventions regard wheelchair. The caresident was at risk falling, impaired continuity of the use of psychotr Interventions to prewhen out of bed" burelated to the position of 10 murse (LPN #1) car interviewed about a instructions or setting LPN #1 reviewed the chair on the care plane in t	dent in wheel chair at nurses and and resident fell face first eft side of head on floorno (sic) The resident was sent from and returned to the facility but injury from the fall. An one evaluation was documented fall for review of the resident's estitioning. An occupation 19/7/17 documented, "Pt is for rock and go w/c in mend to keep chair in the seated in chair and to be seated in chair and seated the seated practical in for Resident #111 was a plan of care or any the seated the seated as an intervention for fall the was nothing else about the an. LPN #1 stated the the rock and go wheelchair in to the facility in March 2017.	{F 2	then monthly x 1 month f and to ensure all areas of been addressed. The Administrator will for of the QI Care Plan Audit Executive Quality Improve Committee monthly x 3 in Executive QI Committee review the QI Care Plan address any issues, concurrends and to make chan to include continued frequenciation monitoring monthly x 3 in the control of the plan address and to make chan to include continued frequenciation monitoring monthly x 3 in the control of the plan address and to make chan to include continued frequenciations.	ward the results t Tools to the vement (QI) nonths. The will meet and Audit Tools and cerns and/or ages as needed, uency of	
	since his admission On 9/13/17 at 10:20	to the facility in March 2017.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495318	B. WING _			R- 09/	-C 13/2017
	ROVIDER OR SUPPLIER			62	REET ADDRESS, CITY, STATE, ZIP CODE 1 BERRY HILL ROAD DUTH BOSTON, VA 24592		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 279}	wheelchair. The rehal and go wheelchair wadevice and not the type residents. The rehal seen Resident #111 had noticed the foot resident was leaning stated she would get evaluated Resident # positioning. On 9/13/17 at 10:50 at the rapist (OT) and re Resident #111 while had go wheelchair. The rock and go chair was not positioned as stated, "He [Resident that he is supposed to resident's feet were seed to move the back of the total more upright positioning was resident's feet on the was immediately able forward on his own. Positioning was committed the trecommendations in the rock nursing was responsitional recommendations. To contact nursing regarchair.	ning in the rock and go ab director stated the rock as a specialized seating pical chair used with a director stated she had earlier today (9/13/17) and rests were up and the forward. The rehab director with the therapist that a.m. the occupational hab director assessed he was seated in the rock he OT stated the back of was reclined too far and as recommended. The OT a #111] is dipped way more be." The OT stated the hupposed to be on the foot after reviewing the resident, at #111] super reclined today when we evaluated him. He ght up." The OT proceeded he rock and go wheelchair attition and placed the foot rests. The resident to to move the wheelchair when asked how the proper municated to direct care hey documented the the clinical record and	{F 2	79}			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		NC	(X3) DATE SURVEY COMPLETED			
		495318	B. WING			R- 09/1	C 1 3/2017
	ROVIDER OR SUPPLIER			STREET ADDRES 621 BERRY HILL SOUTH BOST			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	PROVIDER'S PLAN OF CORRECTIO CH CORRECTIVE ACTION SHOULE SS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 279}	interviewed about prock and go wheeld assisted Resident # earlier in the mornir she positioned the comput him back like the When asked about rests, CNA #1 state [foot rests] are." CN anything about the foot rest. When ask communicated or sithe chair or how to prock and go chair, C stated she used the resident's closet as #111's care card do padded leg rests" b reclining the chair. On 9/13/17 at 1:20 (DON) was interview inability to self-prop wheelchair while restricted the made recommenda positioning. The DOI implemented whate without a getting a pastated the recommendal positioning. The DOI implemented whate without a getting a pastated the recommendal positioning.	g for Resident #111 was ositioning the resident in the hair. CNA #1 stated she had 111 into the rock and go chair ig. When asked about how chair for Resident #111, CNA int was leaning forward so she the chair. CNA #1 stated, "I lat to keep him from falling." the up position of the foot d, "That's just the way they wa #1 stated she did not know rubber band being on the left	{F 2	79}			
	#1) responsible for	p.m. the registered nurse (RN care plan development was					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		R-C	
		495318	B. WING _			09/	13/2017
	ROVIDER OR SUPPLIER			62	TREET ADDRESS, CITY, STATE, ZIP CODE 21 BERRY HILL ROAD OUTH BOSTON, VA 24592		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 279}	chair was listed as an	neelchair. RN #1 stated the intervention for fall ated there were no other an about the chair.	{F 2	79}			
F 310 SS=D	•	ector of nursing during a t 3:20 p.m.	F:	310			10/15/17
	resident and consiste and choices, the facili necessary care and s resident's abilities in a diminish unless circur clinical condition dem	ervices to ensure that a activities of daily living do not mstances of the individual's					
	and services to maint ability to carry out the	a the appropriate treatment ain or improve his or her activities of daily living, fied in paragraph (b) of this					
	provide care and serv	iving. The facility must vices in accordance with following activities of daily					
	(1) Hygiene -bathing, oral care,	dressing, grooming, and					
	(2) Mobility-transfer a walking,	nd ambulation, including					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	
		495318	B. WING			R-	-C 13/2017
NAME OF PI	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	13/2017
DEDDVIII				62	21 BERRY HILL ROAD		
BERRY HI	LL NURSING HOME			s	OUTH BOSTON, VA 24592		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 310	Continued From pag	e 7	F:	310			
	(3) Elimination-toileti	ng,					
	(4) Dining-eating, inc	eluding meals and snacks,					
	(5) Communication,	including					
	(i) Speech,						
	(ii) Language,						
	(iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical				The specialized rock and go chair for		
	record review, the fa wheelchair positionin self-sufficiency for or	cility staff failed to provide ng that enabled ne of 11 residents in the			resident #111 was repositioned on 9/13 by the therapy director to allow the resident to self-propel. The Maintenan	ce	
	self-propel while sea	ident #111 was unable to ted in a specialized "Rock N to improper positioning of the			director made adjustments to the chair 9/13/17 to ensure staff are not able to recline the chair to the point that reside #111 is reclined too far and unable to		
	The findings include:				self-propel. An audit of 100% of residents will be conducted on/or before Sept. 30, 2017	by	
	Resident #111 was a 3/30/17 with diagnos schizophrenia, seizu				Administrative Nursing Staff (Director of Nursing, Assistant Director of Nursing, Staff Facilitator, Quality Improvement	of	
	accident (stroke), dia	betes and high blood num data set (MDS) dated			Nurse and/or Minimum Data Set Nurse identify all residents who utilize a) to	
	7/7/17 assessed Res	sident #111 with severely			wheelchair or other seating device to	c. : c	
		cills and to require the eof two people for transfers.			ensure proper positioning and to identifulation they are able to self-propel the chair. A	-	
		.m. Resident #111 was			resident identified as not being able to self-propel will be referred to Occupation		
		specialized wheelchair in nursing station on his living			Therapy to screen for proper seating to ensure maximum level self-sufficiency		
	·	e wheelchair was reclined.			each resident.	01	
		e front wheels, Resident					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 55 5			R.	-C
		495318	B. WING _			09/	13/2017
NAME OF P	ROVIDER OR SUPPLIER	•	·	S1	FREET ADDRESS, CITY, STATE, ZIP CODE	•	
DEDDY II	ILL NUBEING HOME			62	1 BERRY HILL ROAD		
BERKT H	ILL NURSING HOME			S	OUTH BOSTON, VA 24592		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 310	#111 was leaning for attempting to propose were not supported inches from the floor wheelchair were in foot rest strapped or resident made repein the chair without Resident #111 was 9:30 a.m. and at 10 wheelchair, leaning unsupported. The attempts to propel success. Resident #111's clir resident fell from the forward on 9/6/17. documented, "Resistation leaning forward to the floor hitting leapparent injuries" to the emergency of the same day with coccupational theral in response to the wheelchair and post therapy note dated [patient] appropriat [wheelchair]. Recordined position wis supervised" Resident #111's clir physician's order for The resident's plant documented the reto a history of falling the support of the support of the support of the supervised of the resident's plant documented the reto a history of falling the support of the sup	orward in the wheelchair sel forward. The resident's feet of and were approximately 5 or. The foot rests on the the up position with the left up with a rubber band. The seated efforts to propel forward any forward movement. To observed again on 9/13/17 at 0:00 a.m. seated in the reclined of forward with his feet resident made repeated forward in the chair without Inical record documented the ne wheelchair while leaning A nursing note dated 9/6/17 of the detail of head on floorno If (sic) The resident was sent come and returned to the facility out injury from the fall. An open evaluation was documented fall for review of the resident's sitioning. An occupation 9/7/17 documented, "Pt the for rock and go w/c ommend to keep chair in then seated in chair and to be on a "rock and go" wheelchair. If of care (revised 8/8/17) sident was at risk of falls due go, impaired cognition, impaired to of psychotropic medications.	F3	310	All Nursing staff Certified Nursing Assistants (CNA's), Licensed Practical Nurses (LPN's) and (RN's) have been educated by the Staff Development Coordinator on the requirements for providing proper positioning for resider that utilize specialized seating equipment that enable the maximum level of self-sufficiency by October 15, 2017. An audit will be completed of 10% of residents to include resident #111 week x 8 weeks then monthly x 1 month by Director of Nursing, Assistant Director Nursing, Staff Development Coordinate and/or Quality Improvement Nurse to ensure all residents that utilize specialiseating equipment are able to function their highest level of self-sufficiency in mobility. The Administrator will review a initial the QI Seating Audit Tool weekly weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed. The Administrator will forward the result of the QI Seating Audit Tools to the Executive Quality Improvement (QI) Committee monthly x 3 months. The Executive QI Committee will meet and review the QI Seating Audit Tools and address any issues, concerns and/or trends and to make changes as needed to include continued frequency of monitoring monthly x 3 months.	at's ent kly of or zed at and x 8	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	495318	B. WING		R-C 09/13/2017	
		STREET ADDRESS, CITY, STATE, ZIP CODE 621 BERRY HILL ROAD SOUTH BOSTON, VA 24592			
(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTIVE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROFUNCTION OF THE A		D BE COMPLETION		
Continued From page 9 Interventions to prevent falls included, "Rock-n-go		F 310			
goals and/or interve the use of the chair	ntions in the care plan about or the resident's positioning in				
nurse (LPN #1) cari interviewed about the rock and go chair w LPN #1 stated Resid	ng for Resident #111 was ne resident's positioning in the ith no support for his feet. dent #111 had been in the				
rock and go chair since his admission. LPN #1 stated the resident fell recently from the chair while leaning forward. LPN #1 stated since therapy evaluated the resident on 9/7/17 the back of the chair had been reclined. When asked					
on foot rests, LPN # chair was in the up were on the floor. L was able to self-pro LPN #1 stated she of	1 stated when the back of the position the resident's feet PN #1 stated the resident pel in the rock and go chair.				
she did not see a ph specialized chair.	nysician's order for the				
(rehab) director was #111's current positi wheelchair. The rel and go wheelchair v	interviewed about Resident oning in the rock and go nab director stated the rock was a specialized seating				
residents. The reha seen Resident #111 had noticed the foot resident was leaning stated she would ge	b director stated she had earlier today (9/13/17) and rests were up and the g forward. The rehab director with the therapist that				
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF SUMMARY S) (EACH DEFICIEN REGULATORY OF SUMMARY S) (EACH DEFICIEN REGULATORY OF SUMMARY S) (Interventions to prevent when out of bed." T goals and/or interve the use of the chair the specialized chair the specialized chair since (LPN #1) carriculate (LPN #1) carriculate (LPN #1) carriculate (LPN #1) carriculate (LPN #1) stated Resider ock and go chair with LPN #1 stated Resider ock and go chair with stated the resident for the chair had bee about the resident for the chair had bee about the resident son foot rests, LPN #1 chair was in the upple were on the floor. Lever on the floor. Lever on the floor (LPN #1) stated she continued to the she did not see a phropolar specialized chair. On 9/13/17 at 10:20 (rehab) director was #111's current position wheelchair. The rehat go wheelchair was leaning stated she would get the summary of the stated she would get summary of the summary	A95318 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 Interventions to prevent falls included, "Rock-n-go when out of bed." There were no problems, goals and/or interventions in the care plan about the use of the chair or the resident's positioning in the specialized chair. On 9/13/17 at 10:15 a.m. the licensed practical nurse (LPN #1) caring for Resident #111 was interviewed about the resident's positioning in the rock and go chair with no support for his feet. LPN #1 stated Resident #111 had been in the rock and go chair since his admission. LPN #1 stated the resident fell recently from the chair while leaning forward. LPN #1 stated since therapy evaluated the resident on 9/7/17 the back of the chair had been reclined. When asked about the resident's feet not being on the floor or on foot rests, LPN #1 stated when the back of the chair was in the up position the resident's feet were on the floor. LPN #1 stated the resident was able to self-propel in the rock and go chair. LPN #1 stated she did not know why the rubber band was on the left foot rests. LPN #1 stated she did not see a physician's order for the specialized chair. On 9/13/17 at 10:20 a.m. the rehabilitation (rehab) director was interviewed about Resident #111's current positioning in the rock and go wheelchair. The rehab director stated the rock and go wheelchair. The rehab director stated she had seen Resident #111 earlier today (9/13/17) and had noticed the foot rests were up and the resident was leaning forward. The rehab director stated she had seen Resident #111 earlier today (9/13/17) and had noticed the foot rests were up and the resident was leaning forward. The rehab director stated she had seen Resident #111 earlier today (9/13/17) and had noticed the foot rests were up and the resident was leaning forward. The rehab director stated she would get with the therapist that evaluated Resident #111 and review his	ROVIDER OR SUPPLIER LL NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 Interventions to prevent falls included, "Rock-n-go when out of bed." There were no problems, goals and/or interventions in the care plan about the use of the chair or the resident's positioning in the specialized chair. On 9/13/17 at 10:15 a.m. the licensed practical nurse (LPN #1) caring for Resident #111 was interviewed about the resident's positioning in the rock and go chair with no support for his feet. LPN #1 stated Resident #111 had been in the rock and go chair since his admission. LPN #1 stated the resident fell recently from the chair while leaning forward. LPN #1 stated since therapy evaluated the resident on 9/7/17 the back of the chair had been reclined. When asked about the resident's feet not being on the floor or on foot rests, LPN #1 stated when the back of the chair was in the up position the resident's feet were on the floor. LPN #1 stated the resident was able to self-propel in the rock and go chair. LPN #1 stated she did not see a physician's order for the specialized chair. On 9/13/17 at 10:20 a.m. the rehabilitation (rehab) director was interviewed about Resident #111's current positioning in the rock and go wheelchair. The rehab director stated the rock and go wheelchair was a specialized seating device and not the typical chair used with residents. The rehab director stated she had seen Resident #111 earlier today (9/13/17) and had noticed the foot rests were up and the resident was leaning forward. The rehab director stated she would get with the therapist that evaluated Resident #111 and review his	ROVIDER OR SUPPLIER LL NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY SULL REQUIATION YOR LSC DENTIFYING INFORMATION) Continued From page 9 Interventions to prevent falls included, "Rock-n-go when out of bed." There were no problems, goals and/or interventions in the care plan about the use of the chair or the resident's positioning in the rock and go chair with no support for his feet. LPN #1 stated Resident #111 had been in the rock and go chair since his admission. LPM #1 stated the resident fell recently from the chair was in the up position the resident's feet were on the floor. LPN #1 stated when the back of the chair had been reclined. When asked about the resident's positioning in the rock and go chair since to being on the floor or on foot rests, LPN #1 stated when the back of the chair was in the up position the resident's feet were on the floor. LPN #1 stated when the back of the chair was in the up position the resident's feet were on the floor. LPN #1 stated when the back of the chair was in the up position the resident's feet one of the position the resident's feet were on the floor. LPN #1 stated when the back of the chair was in the up position the resident's feet one of the position the resident's feet one of the position the resident's feet one of the position of the position the resident's feet one of the position the resident's feet one of the position of the position of the resident's feet one of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		405240	B. WING			R-C
NAME OF P	ROVIDER OR SUPPLIER	495318	B. WING _	STREET ADDRESS, CITY, STATE, ZIP C		9/13/2017
	ILL NURSING HOME			621 BERRY HILL ROAD SOUTH BOSTON, VA 24592	30BE	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 310	therapist (OT) and Resident #111 whi and go wheelchair the rock and go ch	50 a.m. the occupational rehab director assessed le he was seated in the rock . The OT stated the back of lair was reclined too far and	F3	310		
	stated, "He [Resid that he is suppose resident's feet wer rests. The OT sta "I found him [Resident not like he was should be more sto move the back to a more upright placed the resident was immediated wheelchair forward the proper position direct care staff, the recommendati	d as recommended. The OT ent #111] is dipped way more id to be." The OT stated the e supposed to be on the foot ted after reviewing the resident, dent #111] super reclined today is when we evaluated him. He raight up." The OT proceeded of the rock and go wheelchair position with a slight recline and it's feet on the foot rests. The ediately able to move the id on his own. When asked how hing was communicated to the OT stated she documented ons in the clinical record and insible for reviewing the				
	aide (CNA #1) car interviewed about rock and go wheel assisted Resident earlier in the morn she positioned the #1 stated the resid reclined the back of put him [Resident from falling." Whe of the foot rests, C way they [foot rest	5 a.m. the certified nurses' ing for Resident #111 was positioning the resident in the chair. CNA #1 stated she had #111 into the rock and go chair ing. When asked about how chair for Resident #111, CNA lent was leaning forward so she of the chair. CNA #1 stated, "I #111] back like that to keep him in asked about the up position ENA #1 stated, "That's just the is] are." CNA #1 stated she did about the rubber band on the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495318	B. WING		R-C 09/13/2017	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 621 BERRY HILL ROAD SOUTH BOSTON, VA 24592	1 09/13/2017	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION	
F 310	left foot rest. When communicated or sh the chair or how to prock and go chair, C stated she used the resident's closet as a #111's care card doop padded leg rests" bureclining the chair. On 9/13/17 at 11:45 observed in the rock feet on the foot rests with a slight recline. self-propelling in the living unit. On 9/13/17 at 1:20 p (DON) was interview inability to self-prope wheelchair while recommendat positioning. The DO implemented whatev without a getting a p stated the recommendat usually communicated aily meetings. These findings were	asked if anyone had own her how far to recline rosition the resident in the NA #1 stated, "No." CNA #1 "care card" posted inside the a guide for care. Resident cumented, "Rock 'N Go - at listed no instructions about a.m. Resident #111 was and go wheelchair with his and the back of the chair The resident was slowly chair down the hall of his o.m. the director of nursing wed about Resident #111's el in the rock and go lined and without foot rests. rapy usually evaluated and ions for safe seating on stated they usually wer therapy recommended hysician's order. The DON indations from therapy were ed to nursing verbally during reviewed with the rector of nursing during a	F 31			